

FORM-VI

Certificate of Disability
(In case of multiple disabilities)
[See Rule 18(1)]

**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE
CERTIFICATE)**

Certificate No.:..... Date:

1. This is to certify that we have carefully examined Shri/Smt./
Kum..... son/wife/daughter
OfShri.....Date of Birth
.....(DD/MM/YYYY) Age.....years, Male/Female
Registration No. Permanent Resident of House No.
Ward/Village/Street whose photograph is
affixed above and are satisfied that:

(A) He/She is a case of **Multiple Disability**. His / Her extent of permanent physical impairment/disability has been evaluated as per guidelines (A) he/she is a case of Multiple Disability. His/her extent of permanent physical impairment/disability has been evaluated as per guidelines (_____ number and date of issue of the guidelines to be specified) for the disabilities ticked below, and is shown against the relevant disability in the table below:

Sl.No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment/ Mental Disability (in%)
1	Locomotors Disability	@		
2	Muscular Dystrophy			
3	Leprosy cured			
4	Dwarfism			
5	Cerebral Palsy			
6	Acid attack Victim			
7	Low vision	#		
8	Blindness	#		
9	Deaf	£		
10	Hard of Hearing	£		
11	Speech and Language disability			
12	Intellectual Disability			
13	Specific Learning Disability			
14	Autism Spectrum Disorder			
15	Mental illness			
16	Chronic Neurological Conditions			
17	Multiple sclerosis			
18	Parkinson's disease			
19	Haemophilia			
20	Thalassemia			
21	Sickle Cell disease			

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (_____number and date of issue of the guidelines to be specified), is as follows:-

In figures:-___percent

In words:- _____ percent

2. This condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary,

or

(ii) is recommended/after___years___months, and therefore this certificate shall be valid till (DD)__(MM)__(YY)___

(DD) (MM) (YY)

@ e.g. Left/right/both arms/legs

e.g. Single eye

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of document	Date of issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority.

Name and Seal of Member	Name and Seal of Member	Name and Seal of Member

Signature/thumb impression of the person in whose favour certificate of disability is issued.
